STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152569	A. BUILDING _____ B. WING _____	R 10/20/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAST EVANSVILLE DIALYSIS PD	**1312 PROFESSIONAL BLVD EVANSVILLE, IN 47714**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{V 000}	INITIAL COMMENTS This was a revisit for the Federal ESRD recertification survey completed on 9-8-2014, 9-9-14, 9-10-14, and 9-11-14. Survey Date: 10-20-14 Facility #: 002562 Medicaid Vendor #: 200071340A Surveyor: Vicki Harmon, RN, PHNS Two (2) conditions and 13 standards were found to be corrected as a result of this survey. East Evansville Dialysis was found to be in compliance with the Conditions for Coverage for ESRD facilities 42 CFR Part 494. Quality Review: Joyce Elder, MSN, BSN, RN October 21, 2014	{V 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.